Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVORIAL HEALTH
ASSOCIATES
5555 FREDERICKSBURG RD STE 102
SAN ANTONIO TX 78229

Respondent Name

CHARTER OAK FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number

MFDR Tracking Number

M4-12-1352-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida Health Associates performed a psychological evaluation and mental health testing on August 22, 2010 for [injured employee]. We also performed Case Management sessions on April 11, 2011 and May 23, 2011. The claims were denied by the carrier per 'peer review.' A 'Peer Review' is a opinion of an evaluator Rule 134.500 DOES NOT state that claims can be denied as not medically necessary based on an opinion or NOT understanding the relation of the medically necessary treatment to the compensable injury of a medical evaluator whom may or may not have had all the patient's medical records for review at the time he/she conducted the peer review nor does it state anywhere that just because the payer deems the services were not medically necessary they can deny payment on these services."

Amount in Dispute: $808.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for Medical Fee Dispute Resolution should be dismissed under Rule 133.307(e)(3)(E) as to dates of service prior to 01-03-2011 as the provider failed to timely submit the request within one year of the date of service as required by Ru8le 133.307©(1). Additionally, the remaining dates of service should be dismissed in accordance with Rule 133.307(e)(3)(G) as the services were denied on the basis of medical necessity."

Response Submitted by: Travelers, 1502 S. Mopac Expressway Ste. A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2010	CPT Code 90801	$752.00	$0.00
April 4, 2011 May 23, 2011	CPT Code 99361	$56.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The dates of service timely submitted in this dispute were denied as unnecessary medical treatment based on peer review by the respondent.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307(c) states, in pertinent part, that "[a]requestor shall timely file with the Division's MDR Section or waive the right to MDR." Rule 133.307(c)(1)(A) explains that "[a]request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." This medical fee dispute was filed on January 3, 2012. The date of service is August 22, 2010. The request for medical fee dispute resolution for the date of service November 5, 2010 was not filed within one year and does not involve issues identified in Rule 133.307(c)(1)(B); therefore the request for this date of service does not meet the requirements of 28 Texas Administrative Code §133.307(c)(1)(A).

2. The division concludes that the requestor has waived the right to medical fee dispute resolution for the August 22, 2010 services.

3. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on January 3, 2012. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.

4. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 24, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.